KENTUCKY CHILD FATALITY REVIEW

FIRST ANNUAL REPORT
JULY 1, 1996 TO JUNE 30, 1997

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EXECUTIVE SUMMARY

Each year 700 to 800 children under the age of eighteen (18) die in the Commonwealth of Kentucky. The leading cause of death is congenital anomalies (birth defects), followed by prematurity, injuries (particularly motor vehicle collisions, fire burns, and drownings), and Sudden Infant Death Syndrome (SIDS). Too many die unnecessarily from preventable causes such as neglect, abuse, suicide and homicide. About half of all child deaths occur during the first year of life. Children one to four years of age appear to be at increased risk for motor vehicle collisions, pedestrian injuries, burns and drownings. Children between the ages of eleven and seventeen appear to be at increased risk of suicide and homicide. Teens between the ages of sixteen and seventeen appear to be at increased risk of motor vehicle collision caused deaths.

Local multidisciplinary investigations and data collection can lead to improved information that enhances identification of cause and manner of deaths and leads to identification of preventable factors that can reduce future child deaths. HB 94, effective July 15, 1996, established the Kentucky Child Fatality Review (KCFR) System under the administration of the Department for Public Health (DPH). Coroners are required to notify local law enforcement agencies, social services workers and local health departments for information relevant to a child death meeting the definition of a coroner's case. Coroners report monthly to DPH and an annual report is produced.

Significant accomplishments during the first year of implementation include:

- Adoption of a uniform reporting form for coroner reporting
- Generation of county, region and state statistical reports
- Appointment and training of a State Team
- Training for local investigators and development of guidance materials
- Expansion of the number of local teams
- Promotion of prevention strategies
- Development of protocols for local investigative teams

Significant findings during the first year of operation of KCFR include:

- Major causes of reported death include: motor vehicle crashes , fire burns, drowning, pedestrian vs. motor vehicle, suicide, bike/go cart vs. motor vehicle, school bus exit/entry, unintentional gun, gun homicide, and abuse.
- Coroner case child deaths were reported by 44 of 120 counties.
- Coroners from 28 of 44 counties suggested preventable factors.
- Jefferson and Fayette counties each had more than 16 child deaths during the year.
- At least 25 counties have local investigative teams that physically meet to review information and identify preventable factors.

Nationally accepted public health messages to reduce future child deaths include:

- Babies should be put to sleep on their backs or sides to reduce the risk of SIDS.
- Infants should be placed in standard, well-maintained bassinets or cribs with properly fitting mattresses to reduce risks of suffocation.
- Infants and children under four years of age or 40 inches in height should be properly secured in approved child restraint systems and children over four should wear proper boosters or seat belts while occupying motor vehicles.
- The number of home fire deaths can be reduced by separating children from fire-starting materials, practicing fire exits, and ensuring that adequate working smoke detectors are in place.
- Helmets should be worn when bike riding to avoid head injuries.
- Reduction of gun availability to children can reduce childhood suicides and homicides.

As a result of the first year of operation, the State Team made the following recommendations to reduce future child deaths:

1. The number of local investigative teams and investigations needs to be increased.
2. Accuracy and completeness of death and birth certificates needs to be improved.
3. Deaths of all children under the age of 18 need to be reviewed.
4. Grief counseling needs to be available for all families experiencing a child death.
5. Public and professional education regarding the child fatality review process, the causes and incidence of child fatalities in Kentucky, and effective preventive strategies needs to be expanded.
6. Parenting classes should be available in communities for expectant parents and parents of all children from birth to 18 years of age.
7. The KCFR database needs to be expanded beyond the coroners report form and death certificate to more accurately identify preventable and risk factors.

FY 96-97 represents the first year of operation for the Kentucky Child Fatality Review System to reduce future deaths of children. Emphasis was given to 1) providing information to coroners, social workers, law enforcement officers, and local health department staff who are required by KRS 211.680 to provide information relevant to a coroner case child death, 2) developing a reporting form and database, 3) organizing a State Team and 4) providing technical assistance and consultation to local investigative teams. Due to limited available data, in-depth statistical analysis was not available for this first annual report.

The focus in FY 97-98 will be 1) expansion and enhancement of local investigation teams, 2) improved data collection and analysis, and 3) identification of data-based prevention strategies.